BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
	)	No. 16-95-52921
PETER CHRISTOPHER SCHOOLER, M.D. 425 West 23rd Street New York, New York 10011	)	OAH No. N-9511042
Physician's & Surgeon's Certificate No. A39937	)	
Respondent.	)	

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective on July 15, 1996.

IT IS SO ORDERED June 13, 1996.

ANABEL ANDERSON-IMBERT, M.D.
Chair, Panel B
Division of Medical Quality

OAH 15 (Rev. 6/84)

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
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In the Matter of the Accusation Against:	No. 16-95-52921
PETER CHRISTOPHER SCHOOLER, M.D. 425 West 23rd Street New York, New York 10011	OAH No. N-9511042
Physician's & Surgeon's Certificate No. A39937	
Respondent.	

PROPOSED DECISION

The matter came on regularly for hearing before Jaime René Román, Administrative Law Judge, Medical Quality Hearing Panel, Office of Administrative Hearings, Sacramento, California, on May 6, 1996.

Complainant was represented by Gail M. Heppell, Deputy Attorney General, Health Quality Enforcement Section, California Department of Justice.

Respondent Peter Christopher Schooler, M.D. (hereinafter "respondent"), although having received notice of the time, date and place of hearing, failed to appear.

Evidence was received and the matter deemed submitted on May 6, 1996.

FINDINGS OF FACT

Procedural Findings

I

Complainant, Douglas Laue, as Acting Executive Director of the Medical Board of California (hereinafter "the Board"), brought the Accusation on October 17, 1995, in his official capacity.

II

On June 20, 1983, respondent was issued Physician and Surgeon Certificate No. A39937 by the Board.

III

All jurisdictional requirements have been met.

Factual Findings

IV

On January 30, 1981, respondent was licensed to practice medicine (No. 145015) in the State of New York. On February 17, 1995, said license was revoked by the Administrative Review Board for Professional Medical Conduct, Department of Health, State of New York, in In the Matter of Peter Christopher Schooler, M.D., ARB No. 94-240, for fraudulently prescribing controlled substances, gross negligence, repeated acts of negligence, failure to maintain adequate records and prescribing and dispensing controlled substances not in good faith and without a legitimate medical purpose.

V

Respondent having failed to appear, no evidence of mitigation, rehabilitation or extenuation was presented.

Costs Findings

VI

The Board incurred $104 as reasonable costs and fees in the investigation and prosecution of this matter.

DETERMINATION OF ISSUES

I

Cause exists to revoke or suspend the certificate of respondent as a physician and surgeon for discipline imposed by another state pursuant to the provisions of Business and Professions Code sections 2234 and 2305 as set forth in Finding Nos. II and IV.

II

Cause exists to direct respondent to pay $104 as and for costs in the investigation, prosecution or enforcement of this

matter pursuant to Business and Professions Code section 125.3 as set forth in Finding No. VI.

III

The objective of this proceeding is to protect the public, the medical profession, maintain professional integrity, its high standards, and preserve public confidence in the medical profession. These proceedings are not for the primary purpose of punishing an individual. (Camacho v. Youde (1979) 95 Cal.App.3d 161, 165).

Giving due consideration to the facts underlying the Accusation (Finding No. IV) and the lack of any evidence of mitigation, rehabilitation or extenuation (Finding No. VI), the public interest will be adversely affected by the continued issuance of a physician's and surgeon's certificate to respondent. (Marek v. Board of Podiatric Medicine (1993) 16 Cal.App.4th 1089, 1093).

ORDER

I

Physician's and Surgeon's Certificate No. A39937 issued to respondent Peter Christopher Schooler, M.D., is revoked pursuant to Determination of Issues Nos. I and III.

II

Respondent Peter Christopher Schooler, M.D., Certificate No. A39937, is hereby ordered to reimburse the Division of Medical Quality the amount of $104 within 90 days from the effective date of this Decision for its investigation and prosecution costs pursuant to Determination of Issues No. II.

Dated: 5-9-96

JAIME RENE ROMAN
Administrative Law Judge
Medical Quality Hearing Panel
Office of Administrative Hearings

REDACTED

DANIEL E. LUNGREN, Attorney General
of the State of California
JANA L. TUTON
Supervising Deputy Attorney General
ROBERT C. MILLER
Deputy Attorney General
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, California 94244-2550
Telephone: (916) 324-5161

Attorneys for Complainant

BEFORE THE DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: PETER CHRISTOPHER SCHOOLER, M.D. 425 West 23rd Street New York NY 10011 Physician's & Surgeon's Certificate No. A39937 Respondent.	No. 16-95-52921 **ACCUSATION**

Douglas Laue, for causes for discipline, alleges:

1. Complainant Douglas Laue makes and files this accusation solely in his official capacity as Acting Executive Director of the Medical Board of California (hereinafter referred to as the "Board") and not otherwise.

2. On or about June 20, 1983, the Medical Board of California issued Physician's and Surgeon's Certificate Number A39937 to Peter Christopher Schooler, M.D. (hereinafter referred to as "respondent"). The certificate was in full force and effect at all times pertinent herein.

/ / /

3. Under Business and Professions Code section 2234, the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct.

4. Under Business and Professions Code section 125.3, the Division may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Division a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

5. Under Business and Professions Code section 2305, the revocation, suspension, or other discipline by another state of a license or certificate to practice medicine issued by the state shall constitute unprofessional conduct against such licensee in this state.

6. Respondent has subjected his physician's and surgeon's certificate to discipline under Business and Professions Code sections 2234 and 2305 as follows:

(A) On or about November 11, 1994, the State of New York Professional Medical Conduct Hearing Committee (hereinafter the "Hearing Committee") issued a Determination and Order which ordered revocation of respondent's medical license due to his professional misconduct in the treatment of five patients. The Hearing Committee charged and found respondent guilty of gross negligence, with negligence on more than one occasion, failure to maintain adequate records, practicing medicine fraudulently, and violating Public Health Law Article 33 (this violation arose from a 1991 Stipulation and Order between respondent and the State of New York Department of Health's Bureau of Controlled Substances)

in that respondent (1) prescribed Valium fraudulently and not in good faith practice of medicine; (2) failed to perform adequate examinations; (3) failed to obtain adequate patient histories and prescribed medication anyway; (4) inappropriately and failed to maintain adequate patient records; (5) failed to order diagnostic laboratory tests in order to determine a patient's HIV status; and (6) prescribed the controlled substance Didrex to a patient for weight reduction for over eight years even though the patient gained rather than lost weight and despite the fact Didrex could be harmful and would not be effective after a period of time. (See attached Exhibit "A.")

(B) On or about February 10, 1995, the State of New York Administrative Review Board of Professional Medical Conduct (hereinafter referred to as the "Review Board") issued its order sustaining the Hearing Committee's determination to revoke respondent's medical license. The Review Board found that revocation was the appropriate penalty for a physician who has used his medical license to commit fraud and who prescribed potentially addictive controlled substance to patients without an appropriate medical purpose and that respondent's misconduct was compounded by proof that he was guilty of egregious and negligent acts. (See attached Exhibit "A.")

WHEREFORE, complainant prays that a hearing be held and that the Medical Board of California make its order:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A39937, issued to Peter Christopher Schooler, M.D.;

/ / /

2. Prohibiting Peter Christopher Schooler, M.D. from supervising physician assistants;

3. Awarding the Board the reasonable costs of the investigation and prosecution of this proceeding pursuant to Business and Professions Code section 125.3; and

4. Taking such other and further action as may be deemed proper and appropriate.

DATED: October 17, 1995

DOUGLAS LAUE, Acting Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

03573-160-SA95AD1439
(PAW 10/6/95)

EXHIBIT A

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Barbara A. DeBuono, M.D., M.P.H.
Commissioner

Karen Schimke
Executive Deputy Commissioner

CERTIFICATION

STATE OF NEW YORK)
ss:
COUNTY OF ALBANY)

ANNE S. BOHENEK, being duly sworn, deposes and says:

I am the Board Coordinator, Office of Professional Medical Conduct, New York State Department of Health. I am an officer having legal custody of the records of the Office of Professional Medical Conduct. I, hereby, certify that the enclosed documents are true copies of documents from the files of the Office of Professional Medical Conduct in the case of Peter C. Schooler, M.D.

ANNE S. BOHENEK, Board Coordinator
OFFICE OF PROFESSIONAL MEDICAL CONDUCT

Sworn to before me this 17 day of [illegible], [illegible].

PATRICIA A. RUTH
Notary Public, State of New York
Qualified in Rensselaer County
Commission expires Feb. 28, 19[illegible]
No. 4524667

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

February 10, 1995

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
NYS Dept. of Health
5 Penn Plaza - Sixth Floor
New York, New York 10001

John Lawrence Kase, Esq.
Kase & Drucker
1325 Franklin Ave. - Suite 225
Garden City, New York 11530

Christian Schooler, M.D.
425 West 23rd Street
New York, New York 10001

RE: In the Matter of Peter Christopher Schooler
Effective Date: 02/17/95

Dear Mr. Smith, Mr. Kase and Dr. Schooler :

Enclosed please find the Determination and Order (No. 94-220) of the Professional Medical Conduct Administrative Review Board in the above referenced matter. This Determination and Order shall be deemed effective upon receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Empire State Plaza
Corning Tower, Room 438
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

This exhausts all administrative remedies in this matter [PHL §230-c(5)].

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
ADMINISTRATIVE REVIEW BOARD FOR
PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

PETER CHRISTOPHER SCHOOLER, M.D.

ADMINISTRATIVE REVIEW BOARD DECISION AND ORDER NUMBER ARB NO. 94-240

A quorum of the Administrative Review Board for Professional Medical Conduct (hereinafter the "Review Board"), consisting of **ROBERT M. BRIBER, SUMNER SHAPIRO, EDWARD C. SINNOTT, M.D.** and **WILLIAM A. STEWART, M.D.**[1] held deliberations on January 13, 1995 to review the Hearing Committee on Professional Medical Conduct's (Hearing Committee) November 10, 1994 Determination finding Dr. Peter Christopher Schooler (Respondent) guilty of professional misconduct. The Respondent requested the Review through a Notice which the Board received on November 17, 1994. James F. Horan served as Administrative Officer to the Review Board. John Lawrence Kase, Esq. filed a brief for the Respondent, which the Review Board received on December 21, 1994. David W. Smith, Esq. filed a brief for the Office of Professional Medical Conduct (Petitioner), which the Review Board received on January 3, 1995.

SCOPE OF REVIEW

New York Public Health Law (PHL) §230(10)(i), §230-c(1) and §230-c(4)(b) provide that the Review Board shall review:

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[1]Drs. Stewart participated in the deliberations by conference call. Dr. Price did not participate in the deliberations.

- whether or not a hearing committee determination and penalty are consistent with the hearing committee's findings of fact and conclusions of law; and
- whether or not the penalty is appropriate and within the scope of penalties permitted by PHL §230-a.

Public Health Law §230-c(4)(b) permits the Review Board to remand a case to the Hearing Committee for further consideration.

Public Health Law §230-c(4)(c) provides that the Review Board's Determinations shall be based upon a majority concurrence of the Review Board.

HEARING COMMITTEE DETERMINATION

The Petitioner charged the Respondent with practicing medicine with negligence on more than one occasion, with gross negligence, with failure to maintain adequate records and with practicing medicine fraudulently. The Petitioner also charged the Respondent with violating Public Health Law Article 33. The negligence charges and the records charge arose from the Respondent's treatment of five of the Respondent's patients, whom the record refers to by the initials A through E, and from the Respondent's treatment of an undercover investigator posing as a patient, whom the record refers to as Patient B[redacted]. The fraud charge arose from the treatment for Patient B[redacted]. The Article 33 charge arose from a 1991 Stipulation and Order between the Respondent and the New York State Department of Health's Bureau of Controlled Substances. That charge also involved the treatment for Patient B[redacted]

The Committee found that the Respondent had entered into a Stipulation with the Department of Health in which the Respondent admitted to violating Public Health Law Article 33, in that the Respondent prescribed and dispensed controlled substances not in good faith, nor in the course of his professional practice, nor for legitimate medical purposes and that the Respondent wilfully made false statements on prescriptions for controlled substances. The Stipulation and Order imposed a Thirty Thousand ($30,000) Dollar civil penalty, with half that amount stayed, and suspended the Respondent's authority to use Official New York State prescription forms for one year.

The Committee found the Respondent guilty of fraud in his treatment of Patient B[redacted] The Hearing Committee found, based on the Respondent's admission in the 1991 Stipulation and Order, that the Respondent had prescribed Valium fraudulently and not in the good faith practice of medicine.

The Committee found that the Respondent was guilty of negligence on more than one occasion in treating Patient B[redacted] and Patients A through E for failing to perform adequate examinations and/or failing to obtain adequate patient histories and for prescribing medications inappropriately. The Committee also found the Respondent guilty of failing to maintain adequate records for Patient B[redacted] and Patients A through E.

The Committee found that the Respondent was guilty of gross negligence in his treatment of Patients A and C. In the case of Patient A, the Committee found that the Respondent had failed to order diagnostic laboratory tests to determine the Patient's HIV status, even though the Patient was a gay man who had presented with a rash, congestion, a cough and significant weight loss. Ten days following Patient A's last visit with the Respondent a second physician diagnosed the Patient as suffering from Karposi's sarcoma and a blood test confirmed that the Patient was suffering from active AIDS. In the case of Patient C, the Committee found that the Respondent had prescribed the controlled substance Didrex for the Patient for weight reduction over a period of eight years. The Committee found that the Respondent was unaware that Didrex could be harmful, that the Respondent was aware that Didrex would not be effective after a period of time, that the Patient failed to lose weight and that the Patient actually weighed 46 pounds more at the end of the eight years of treatment with Didrex than at the beginning.

The Committee voted to revoke the Respondent's license to practice medicine in New York State.

REQUESTS FOR REVIEW

The Respondent asks the Review Board to overturn the Hearing Committee's Determination that the Respondent was guilty of gross negligence, negligence on more than one occasion and fraud.

The Respondent also argues that the Committee's penalty is unnecessarily harsh because the only charges actually proved at the hearing were ignorance of record keeping and prescribing requirements.

The Respondent argues that the Respondent was not guilty of fraudulent practice arising from the care for Patient B[redacted] because there was no demonstration that the Respondent intended to practice fraudulently.

The Respondent argues that he can not be held responsible for failing to order tests for Patient A, because Patient A refused to be tested for AIDS. The Respondent argues that in the case of Patient C, in the context of the entire treatment, the prescription for Didrex was neither negligent nor grossly negligent. The Respondent also argues that the treatment of the other patients was adequate.

The Respondent admits that his record keeping was poor and characterizes his treatment for Patient B[redacted] as an aberration. The Respondent states that he has taken training in dispensing controlled substances and record keeping and has remedied the deficiencies in his practice. The Respondent asks that the Board also consider mitigating factors such as the Respondent's work with an underserved population and his large amount of work for patients who are unable to pay.

The Respondent argues that revocation is a harsh penalty for errors in record keeping and prescribing. The Respondent suggests that some reeducation and monitoring of his records would be an appropriate penalty.

The Petitioner opposes the Respondent's request that the Review Board overturn the Hearing Committee's Determination. The Petitioner argues that the Review Board has no authority to reverse the Hearing Committee's findings of fact in this case. The Petitioner argues that the findings and the penalty are consistent and that revocation of the Respondent's license is the appropriate penalty in this case.

REVIEW BOARD DETERMINATION

The Review Board has considered the entire record below and the briefs which counsel have submitted.

The Review Board amends the Hearing Committee's Determination to correct an error on page

5 paragraph 8 of the Committee's Determination. The first line of paragraph 8 should read that the Stipulation and Order in the Respondent's Article 33 case was dated July 26, 1991, rather than July 26, 1994.

The Review Board votes 3-1 to sustain the Hearing Committee's Determination finding the Respondent guilty of negligence on more than one occasion, gross negligence, failure to maintain adequate records, violation of Public Heath Law Article 33 and fraud in the practice of medicine. The Respondent did not contest the portion of the Determination which found the Respondent guilty of the Article 33 violations or failing to maintain adequate records.

The Hearing Committee's Determination that the Respondent committed fraud in treating Patient B[redacted] is consistent with the Committee's findings that the Respondent prescribed Valium for the Patient, although the Patient never gave the Respondent a valid medical reason for the prescriptions, that the Respondent later increased the dosage of Valium, that the Respondent admitted to giving the prescriptions to the Patient fraudulently and that the Respondent did not prescribe Valium for the Patient in the good faith practice of medicine.

The Hearing Committee Determination that the Respondent was guilty of negligence on more than one occasion is consistent with the Committee's findings that the Respondent failed to perform adequate tests or obtain adequate histories and in some cases prescribed medications inappropriately for Patient B[redacted] and for Patients A through E.

The Committee's Determination that the Respondent was guilty of gross negligence was consistent with the Committee's findings concerning the treatment of Patients A and C. Despite the Respondent's concentrating much of his practice to treating persons with AIDS, the Respondent failed to perform adequate tests to diagnose Patient A's HIV status. The Respondent also continued to prescribe Didrex for weight reduction for Patient C over a period of eight years, even though the Patient gained rather than lost weight, and despite the fact that Didrex could be harmful and would not be effective over a period of time.

The Review Board votes 3-1 to sustain to the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State. The Committee's Penalty is consistent with the Respondent's Determination that the Respondent was guilty of fraud in the practice

of medicine, gross negligence, negligence on more than one occasion, failure to maintain adequate records and violating Public Health Law Article 33. The Committee's Penalty would have been appropriate if the Respondent's only misconduct had been fraudulently prescribing controlled substances. Revocation is the appropriate penalty for a physician who uses his medical license to commit fraud and who prescribes potentially addictive controlled substances to patients without an appropriate medical purpose. The Respondent's misconduct was compounded by proof that the Respondent was guilty of multiple and in two instances, egregious acts of negligence in treating the Patients whose cases were reviewed in this hearing.

ORDER

NOW, based upon this Determination, the Review Board issues the following **ORDER**:

1. The Review Board votes 4-0 to **amend** the Hearing Committee's Determination as noted in the Determination.

2. The Review Board votes 3-1 to **sustain** the Hearing Committee on Professional Medical Conduct's November 10, 1994 Determination finding Dr. Peter Christopher Schooler guilty of professional misconduct.

3. The Review Board votes 3-1 to **sustain** the Hearing Committee's Determination revoking the Respondent's license to practice medicine in New York State.

ROBERT M. BRIBER
SUMNER SHAPIRO
EDWARD SINNOTT, M.D.
WILLIAM A. STEWART, M.D.

IN THE MATTER OF PETER CHRISTOPHER SCHOOLER, M.D.

ROBERT M. BRIBER, a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schooler.

DATED: Albany, New York

Jan 21 , 1995

ROBERT M. BRIBER

IN THE MATTER OF PETER CHRISTOPHER SCHOOLER, M.D.

SUMNER SHAPIRO, a member of the Administrative Review Board for Professional Medical Conduct, affirms that the attached Determination and Order represents the decision by the majority of the Review Board in the case of Mr. Schooler.

DATED: Delmar, New York

FEB. 6, 1995

SUMNER SHAPIRO

page 10
is missing
from original

IN THE MATTER OF PETER CHRISTOPHER SCHOOLER, M.D.

EDWARD C. SINNOTT, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schooler.

DATED: Roslyn, New York
January 19, **1995**

EDWARD C. SINNOTT, M.D.

IN THE MATTER OF PETER CHRISTOPHER SCHOOLER, M.D.

WILLIAM A. STEWART, M.D., a member of the Administrative Review Board for Professional Medical Conduct, concurs in the Determination and Order in the Matter of Dr. Schooler.

DATED: Syracuse, New York

19 Jan , **1995**

William A Stewart

WILLIAM A. STEWART, M.D.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Mark R. Chassin, M.D., M.P.P., M.P.H.
Commissioner

Paula Wilson
Executive Deputy Commissioner

November 10, 1994

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

David W. Smith, Esq.
Associate Counsel
NYS Department of Health
5 Penn Plaza-6th Floor
New York, NY 10001

John Lawrence Kase, Esq.
Messrs Kase & Drucker
1325 Franklin Avenue
Suite 225
Garden City, NY 11530

Christian Schooler, M.D.
425 West 23rd Street
New York, NY 10001

RE: In the Matter of Peter Christopher Schooler, M.D.

Dear Mr. Smith, Mr. Kase and Dr. Schooler:

Enclosed please find the Determination and Order (No. 94-240) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt **or** seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine if said license has been revoked, annulled, suspended or surrendered, together with the registration certificate. Delivery shall be by either **certified mail or in person** to:

Office of Professional Medical Conduct
New York State Department of Health
Corning Tower - Fourth Floor (Room 438)
Empire State Plaza
Albany, New York 12237

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "(t)he determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays all action until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by **certified mail**, upon the Administrative Review Board **and** the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Empire State Plaza
Corning Tower, Room 2503
Albany, New York 12237-0030

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:rlw

Enclosure

STATE OR NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT
----------X

IN THE MATTER	:	DETERMINATION
OF	:	AND
PETER CHRISTOPHER SCHOOLER, M.D.	:	ORDER
----------X		BPMC-94-240

Thea Graves Pellman, Chairperson, **Michael R. Golding, M.D.**, and **Jack Schnee, M.D.**, duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law, served as the Hearing Committee in this matter pursuant to Sections 230(10)(e) of the Public Health Law. **Michael P. McDermott, Esq.,** Administrative Law Judge, served as Administrative Officer for the Hearing Committee.

After consideration of the entire record, the Hearing Committee submits this DETERMINATION AND ORDER.

STATEMENT OF CHARGES

Essentially, the Statement of Charges charges the Respondent with violation of Article 33 of the Public Health Law; with practicing the profession fraudulently; with practicing with negligence on more than one occasion; with practicing with gross negligence and with failure to maintain record.

The charges are more specifically set forth in the Statement of Charges, a copy of which is attached hereto and made a part of this DETERMINATION AND ORDER.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges:	June 14, 1994
Pre-Hearing Conference:	July 21, 1994
Hearing Dates:	July 28, 1994 August 30, 1994 August 31, 1994
Place of Hearing:	NYS Department of Health 5 Penn Plaza New York, New York
Date of Deliberations:	October 11, 1994
Petitioner Appeared By:	Peter J. Millock, Esq. General Counsel NYS Department of Health By: David W. Smith, Esq. Associate Counsel
Respondent Appeared By:	John Lawrence Kase, Esq. Kase & Drucker 1325 Franklin Ave., Suite 225 Garden City, New York 11530

WITNESSES

For the Petitioner:

Herbert Gershberg, M.D.

Peter Benjamin Berkey, M.D.

Fred Baitaglia

For the Respondent:

Peter Christopher Schooler, M.D., the Respondent

Patient D

Patient X

Patient Y

Patient Z

FINDINGS OF FACT

Numbers in parenthesis refer to transcript pages or exhibits. These citations represent evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the evidence cited. All hearing Committee findings were unanimous unless otherwise specified.

GENERAL FINDINGS

1. Dr. Christopher Schooler was duly licensed to practice medicine in New York State on January 30, 1981, under license number 145015 (Pets. Exs. 1 and 2).

2. Dr. Schooler is a graduate of the University of Brussels, where he received his medical degree in June, 1979. (Pet's Ex. 2; Tr. 260).

3. Dr. Schooler was an intern at St. Clare's Hospital and St. Elizabeth's Hospital in New York City (Tr. 259-260, 339).

4. Thereafter, he began working with Dr. Benjamin Shalette, a single practitioner in his 80's in 1981. Six months later Dr. Shalette retired, and Dr. Schooler continued the practice. (Tr. 260, 343).

5. Dr. Schooler remains in practice as a general practitioner in the West Side, at 425 West 23rd Street, New York, New York.

6. Dr. Schooler devotes a significant portion of his practice to problems of the local community. Approximately 60% of his patients are HIV infected, or have active AIDs (TR 267, 279). Such patients typically lose their jobs and therefore, both their health insurance and their ability to earn a living are affected. Dr. Schooler claims to treat these patients free of charge when they cease to have resources. Approximately 10-15% of his practice consists of these pro bono patients. (Tr. 260, 343).

7. There is also a large portion of his practice which is transsexual (Tr. 267).

FINDINGS AS TO ARTICLE 33 VIOLATIONS

8. By Stipulation and Order, dated July 26, 1994, the Respondent entered into a Stipulation with the New York State Department of Health, Bureau of Controlled Substances, whereby the Respondent admitted to, and the Commissioner of Health found, violations of Article 33 of the N.Y. Public Health Law, in that the Respondent prescribed and dispensed controlled substances not in good faith, nor in the course of his professional practice, nor for legitimate medical purposes and willfully made false statements on prescriptions for controlled substances. The Respondent was fined $30,000,00, payment of $15,000.00 of which was suspended pending lawful conduct by the Respondent for three years from the date of the Order, and his right to issue prescriptions on official New York State prescription forms was suspended for one year. (Pet's Ex. 3).

FINDINGS AS TO PATIENT "FRANK B[redacted]"

(Frank B[redacted] was a fictitious name used by an undercover narcotic agent (Tr. 184-185)).

9. The Respondent first saw Patient B[redacted] on November 7, 1988. He saw the Patient five times between November 7, 1988 and January 23, 1989 (Pet's Ex. 4; Tr. 184-193).

10. No adequate physical examination was ever performed nor was an adequate medical history ever taken (Pet's Ex. 4; Tr. 17, 184-193).

11. Patient B[redacted] continually received prescriptions for Valium, although he never gave the Respondent a valid medical reason for such prescriptions (Pet's Ex. 4; Tr. 196).

12. On the fourth and fifth visits, June 4, 1989 and July 23, 1989, the dosage of Valium was increased without medical justification (Pet's Ex. 4; Tr. 17-18, 188-192).

13. The Respondent has admitted that he gave the Valium prescriptions to Patient B[redacted] fraudulently, and not in the good faith practice of medicine (Pet's Ex. 3).

14. The care rendered to Patient B[redacted] by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 4; Tr. 18-19, 263).

CONCLUSIONS AS TO PATIENT "FRANK B[redacted]"

1. The care rendered to Patient B[redacted] by the Respondent did not meet the minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient B[redacted] do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT A

15. The Respondent first saw Patient A in June 8, 1988. The patient's second visit was on July 14, 1990. No adequate physical examination was ever performed, nor was an adequate medical history ever taken (Pet's Ex. 5, 5A; Tr. 35-37).

16. Patient A's next visit was on February 12, 1991. He had a rash, which the Respondent diagnosed as a fungal infection (Pet's Exs. 5, 5A; Tr. 36). The patient's next visit was on April 18, 1991, and the same diagnosis was made (Pet's Exs. 5, 5A; Tr. 35-36; 162-164).

17. On the last visit, May 18, 1991, Patient A weighed 185 pounds which was 33 pounds less than he had weighed 11 months prior, but the Respondent did not determine the etiology of the weight loss. The Respondent also diagnosed Patient A's cough as bronchitis (Pet's Ex. 5, 5A; Tr. 36-39).

18. The Respondent knew that Patient A. was gay and at risk for HIV infection. Nevertheless, he never did any diagnostic laboratory tests to identify the patient's HIV status (Pet's Ex. 5, 5A; Tr. 275, 345-346).

19. On May 28, 1991, ten days after his last visit to the Respondent, Patient A saw Dr. Peter Berkey whom he knew was an infectious disease specialist, for treatment (Pet's Ex. 5, 5A; 159-161, 166-174). When Dr. Berkey first saw Patient A he was aware of the possibility that the patient could have AIDS (Tr. 161-166).

20. Dr. Berkey noted that Patient A had Kaposi's sarcoma, a frequent indicator of AIDs in a patient, as well as a thrush infection in his mouth. However, the patient was not malnourished. Dr. Berkey formed an opinion the patient had active AIDs and confirmed this opinion with a blood test. The patient consented to this testing (Tr. 161-163).

21. The Respondent thought that Patient A had stopped his visits because he had cured him of bronchitis (Tr. 411-412).

22. Patient A died of complications of AIDs in 1993 (Tr. 165).

23. The care rendered to Patient A by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Exs. 5, 5A; Tr. 38-39, 47-65, 263, 347-350).

CONCLUSIONS AS TO PATIENT A

1. The care rendered to Patient A by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient A do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT B

24. Patient B was first seen on July 11, 1988, and for almost the next three years the Respondent simultaneously prescribed Dalmane and Valium or similar acting substitutes for the patient (Pet's. Ex. 6; Tr. 66, 71, 95-96).

25. Taking Dalmane and Valium together could be dangerous, but the Respondent was unaware of this fact (Pet's Ex. 6; Tr. 95-96, 412-416). The Respondent did not monitor Patient B in the taking of these drugs (Pet's Ex. 6; Tr. 76-77, 92, 94).

26. The Respondent attempted to convince Patient B to decrease and eventually give up taking the Valium (Tr. 353). There were many psychiatric referrals during the course of the treatment in an attempt to find a psychiatrist with whom the patient would be comfortable (Tr. 69, 74, 87, 352). At one point, February 24, 1990, there appears a notation in the file that the patient signed an agreement to cease taking Valium and Dalmane by a date certain (Pet's Ex. 6, P.6; Tr. 80).

27. On March 8, 1990, the patient complained of palpitations and the Respondent ordered an EKG which was appropriate (Pet's Ex. 6; Tr. 99-100).

28. The Respondent also diagnosed Patient B with hyperventilation but never recorded a respiratory rate (Pet's Ex. 6; Tr. 99-100).

29. The Respondent never performed an adequate physical examination on Patient B, nor did he ever take an adequate medical history of the patient (Pet's Ex. 6; Tr. 76-77, 99-100, 107-108).

30. The care rendered to Patient B by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 6; Tr. 76-108, 263).

CONCLUSIONS AS TO PATIENT B

1. The care rendered to Patient B by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient B do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT C

31. The Respondent first saw Patient C on January 11, 1983. Patient C was overweight and hypertensive (Pets Ex. 7; Tr. 248-249).

32. The Respondent prescribed anti-hypertensive medication to lower the patient's blood pressure, and he also prescribed Didrex for weight reduction. He continued to prescribe Didrex for the next eight years (Pet's. Ex. 7; Tr. 248-249).

33. Patient C never lost weight, and at the end of eight years he weighed 46 pounds more than he did when he first started seeing the Respondent (Pet's Ex. 7; Tr. 252-253).

34. The Respondent was not aware that Didrex could be harmful. However, he was aware that it would not be effective after a period of time, but he continued to prescribe it as a placebo (Pet's Ex. 7; Tr. 382-383, 394-395).

35. During the eight years that he treated Patient C, the Respondent never performed an adequate physical examination of the patient, nor did he ever obtain an adequate medical history (Pet's Ex. 7; Tr. 252-253).

36. Dr. Schooler engaged in counseling Patient C in an attempt to have him lose weight; stop taking Didrex, to stop smoking and to control his blood pressure (Tr. 261-262).

37. Dr. Schooler has acknowledged that the Didrex prescriptions represented a misguided effort to assist Patient C, and that he would not treat this patient again in the same manner (Tr. 383).

38. The care rendered to Patient C by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's. Ex. 7; Tr. 263).

CONCLUSIONS AS TO PATIENT C

1. The care rendered to Patient C by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent;'s medical records for Patient C do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT D

39. The Respondent first saw Patient D on September 3, 1987. From February 22, 1992 to November 20, 1993, the Respondent continually prescribed Darvocet and Meprobamate for the patient and added Procardia on May 27, 1992 and Placidyl on October 22, 1992. There is noting in the patient's medical record to justify the prescribing of these drugs (Pet';s Exs. 8, 8A; Tr. 115-121, 302-303).

40. Patient D was being treated by a psychiatrist, a gynecologist and a gastro-enterologist at the same time she was being treated by the Respondent (Tr. 302, 308-310).

41. The Respondent did not secure the records of patient D's other treating physicians to have as part of his own medical record on this patient (Tr. 354, 357-358).

42. Patient D testified on behalf of the Respondent. She stated that his office was neat and clean, his practice well run, and that a nurse took her history when she came in (Tr. 305).

43. The Respondent never recorded an adequate physical examination on Patient D and he failed to record an adequate medical history of the patient (Pet's Ex. 8 & 8A).

44. The care rendered to Patient D by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 8; Tr. 120, 263, 378).

CONCLUSIONS AS TO PATIENT D

1. The care rendered to Patient D by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for Patient D do not accurately reflect the evaluation and treatment of the patient.

FINDINGS AS TO PATIENT E

45. The Respondent treated Patient E from May 2, 1990 through March 14, 1994. He diagnosed hypertension and continually prescribed Inderal and Meprobamate during the course of treatment (Pet's Ex. 9, 9A; Tr. 127-130, 243).

46. Patient E's medical record does not reflect that the patient actually suffered from hypertension (Pet's Ex. 9, 9A).

47. The Respondent's prescribing of Inderal was not justified since none of the blood pressure readings recorded for Patient E indicated hypertension. Likewise, the prescribing of Meprobamate for "anxiety", without further elaboration, was also unjustified (Pet's Ex. 9, 9A; Tr. 129-134).

48. Patient E was being treated by other physicians while seeing the Respondent, but the Respondent did not obtain any records from the other treating physicians to have as part of his own records on this patient (Pet's Exs. 9, 9A; Tr. 130)

49. The care rendered to Patient E by the Respondent did not meet minimum acceptable medical standards and the patient's records do not accurately reflect the evaluation and treatment of the patient (Pet's Ex. 9; Tr. 131-132, 263).

CONCLUSIONS AS TO PATIENT E

1. The care rendered to Patient E by the Respondent did not meet minimum acceptable standards of medical care.

2. The Respondent's medical records for patient E do not accurately reflect the evaluation and treatment of the patient.

VOTE OF THE HEARING COMMITTEE

(All votes were unanimous unless otherwise indicated)

FIRST SPECIFICATION: (VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW)

SUSTAINED

SECOND SPECIFICATION: (PRACTICING THE PROFESSION FRAUDULENTLY)

SUSTAINED

THIRD SPECIFICATION: (PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION)

SUSTAINED

FOURTH AND FIFTH SPECIFICATIONS: (PRACTICING WITH GROSS NEGLIGENCE)

SUSTAINED

SIXTH THROUGH ELEVENTH SPECIFICATION: (FAILURE TO MAINTAIN RECORDS)

SUSTAINED

DETERMINATION OF THE HEARING COMMITTEE AS TO PENALTY

The Hearing Committee has reviewed the entire record in this case. The record reveals that the Respondent's treatment of "Patient B[redacted] and patients A, B, C, D and E, in each and every case, did not meet minimum acceptable standards of medical care.

In addition, the record reveals that the Respondent prescribed and dispensed controlled substances, not in good faith, nor in the course of his professional practice, nor for legitimate medical purposes and wilfully made false statements on prescriptions for controlled substances.

The Hearing Committee has unanimously (3-0) **SUSTAINED** all of the charges against the Respondent.

The Hearing Committee determines unanimously (3-0) that the Respondent's license to practice medicine in the State of New York should be **REVOKED**.

The Hearing Committee recommends to the licensing authority that should the Respondent apply in the future for reinstatement of his license to practice medicine, no action be taken on said application unless it is accompanied by documentation showing that the Respondent has successfully completed appropriate retraining courses in medical practice and ethics.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Respondents license to practice medicine in the State of New York is **REVOKED.**

2. This ORDER shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

Dated: W. Hempstead, **New York**
Nov 9 , **1994**

THEA GRAVES PELLMAN (Chairperson)

MICHAEL R. GOLDING, M.D.
JACK SCHNEE, M.D.

NEW YORK STATE : PARTMENT OF HEATLH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

X

IN THE MATTER OF :

: AFFIDAVIT OF SERVICE

:

CHRISTIAN SCHOOLER M.D. X

STATE OF NEW YORK)
COUNTY OF) SS:

Lawrence M Mattei, being duly sworn, states:

1. I am over eighteen years of age and am not a party to the above-captioned proceeding.

2. I am employed by the New York State Department of Health's Office of Professional Medical Conduct as a Sr. Medical Conduct Investigator

3. I served the annexed Notice of Hearing & Statement of Charges upon Christian Schooler M.D. by going to 425 W 23rd St NYC, N.Y. on 6/23, 1994, at approximately 3:23 a.m. (p.m.) and handing said person a true copy thereof.

4. A description of the person so served is as follows:
Approx. age: 45; Approx. weight 150 lbs; Approx. height: 5'6"; Sex Male; Skin Color: White; Hair Color: Gray;
Other identifying characteristics: _____

PLAINTIFF'S
DEFENDANT'S EXHIBIT 1
COMPANY'S
DEPARTMENT'S
PETITIONER'S for identification
RESPONDENT'S in evidence
DATE 7/19/94 REPORTER
ALDING REPORTING SERVICE, INC.

Lawrence M. Mattei
SIGNATURE

Sworn to before me
on this 14th day of
June, 1994

ALBERT BALDASSARRI
Notary Public, State of New York
No. 31-4977559
Qualified in New York County
Commission Expires

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER OF CHRISTIAN SCHOOLER, M.D.	NOTICE OF HEARING

TO: CHRISTIAN SCHOOLER, M.D.
425 West 23rd Street
New York, New York 10011

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994) and N.Y. State Admin. Proc. Act Sections 301-307 and 401 (McKinney 1984 and Supp. 1994). The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 28th day of July, 1994, at 10:00 in the forenoon of that day at 5 Penn Plaza, Sixth Floor, New York, New York 10001 and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce

witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Administrative Law Judge's Office, Empire State Plaza, Tower Building, 25th Floor, Albany, New York 12237, (518-473-1385), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230 (McKinney 1990 and Supp. 1994), you may file an answer to the Statement of Charges not less than ten days prior to the date of the hearing. If you wish to raise an affirmative defense, however, N.Y. Admin. Code tit. 10, Section 51.5(c) requires that an answer be filed, but allows the filing of such an answer until three days prior to the date of the hearing. Any answer shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the

Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a (McKinney Supp. 1994). YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: New York, New York

June 14, 1994

CHRIS STERN HYMAN,
Counsel

Inquiries should be directed to: DAVID W. SMITH
Associate Counsel
Bureau of Professional
Medical Conduct
5 Penn Plaza, 6th Floor
New York, New York 10001
Telephone No.: 212-613-2617

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

----------X

IN THE MATTER	:	STATEMENT
OF	:	OF
CHRISTOPHER SCHOOLER, M.D.	:	CHARGES

----------X

CHRISTOPHER SCHOOLER, M.D., the Respondent, was authorized to practice medicine in New York State on January 30, 1981 by the issuance of license number 145015 by the New York State Education Department. The Respondent is currently registered with the New York State Education Department to practice medicine for the period January 1, 1993 through December 31, 1994.

FACTUAL ALLEGATIONS

A. By Stipulation and Order dated on or about July 26, 1991, Respondent entered into a Stipulation with the New York State Department of Health, Bureau of Controlled Substances, whereby Respondent admitted to, and the Commissioner of Health found, violations of Article 33 of the N.Y. Public Health Law, in that Respondent dispensed controlled substances not in the good faith practice of medicine and willfully and knowingly made false statements on prescriptions for controlled substances. Respondent was

fined $30,000.00, payment of $15,000.00 of which was suspended pending lawful conduct by Respondent for three years from the date of the Order, and his right to issue prescriptions on official New York State prescription forms was suspended for one year.

B. On or about November 14, 1988, January 4, 1989, and January 23, 1989, Respondent willfully and knowingly issued prescriptions not in the good faith practice of medicine and without an adequate medical history or an adequate physical examination to an investigator posing as patient Frank B[redacted].

C. Between in or about July, 1988 and May, 1991, Respondent treated Patient A for anxiety and other medical conditions approximately five (5) times at his office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Despite the fact that Patient A presented to Respondent with skin rash, chest congestion and sudden weight loss, Respondent failed to order or perform indicated laboratory tests, or note such tests, if any, failed to prescribe indicated medicines, or note such prescriptions, if any, and failed to diagnose Patient A as HIV Positive and having AIDS or note such diagnosis, if any.

D. Between in or about July, 1988, and February, 1991, Respondent treated Patient B for anxiety and other medical conditions at his office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Throughout the period, Respondent inappropriately prescribed controlled substances including Valium and Dalmane.

4. Respondent failed to warn Patient B about the possible addictive effects of Valium and Dalmane taken together, or note such warnings, if any, and failed to monitor possible adverse side effects of the controlled substances he was prescribing, or note such monitoring, if any.

E. From in or about January, 1983 through January, 1989, Respondent treated Patient C for hypertension and other medical conditions at his medical office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Throughout the period, Respondent inappropriately prescribed Didrex, which, among other things, was contra-indicated, and other controlled substances, including Dalmane.

F. From in or about August, 1992, through in or about May, 1993, Respondent treated Patient D for anxiety and other medical conditions at his medical office at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Throughout the period, Respondent inappropriately prescribed controlled substances including Meprobomate and Darvocet.

G. From in or about September, 1991 through June, 1993, Respondent treated Patient E for hypertension and other medical conditions at his medical offices at 425 West 23rd Street, New York City.

1. Throughout the period, Respondent failed to obtain an adequate medical history, or note such history, if any.

2. Throughout the period, Respondent failed to perform an adequate physical examination, or note such examination, if any.

3. Throughout the period, Respondent inappropriately prescribed Inderal and Meprobamate.

SPECIFICATION OF CHARGES

FIRST SPECIFICATION

VIOLATION OF ARTICLE 33 OF THE PUBLIC HEALTH LAW

Respondent is charged with having been found by the Commissioner of Health to be in violation of Article 33 of the Public Health Law within the meaning of N.Y. Educ. Law Section 6530(9)(e)(McKinney Supp. 1994). Specifically, Petitioner charges:

1. The facts in Paragraph A.

SECOND SPECIFICATION

PRACTICING THE PROFESSION FRAUDULENTLY

Respondent is charged with practicing the profession fraudulently within the meaning of N.Y. Educ. Law Section 6530(2)(McKinney Supp. 1994). Specifically, Petitioner charges:

2. The facts in Paragraph B.

THIRD SPECIFICATION

PRACTICING WITH NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with practicing the profession with negligence on more than one occasion within the meaning of N.Y. Educ. Law Section 6530(3)(McKinney Supp. 1994). Specifically, Petitioner charges two or more of the following:

3. The facts in Paragraph B; C and C1-3; D and D1-3; E and E1-3; F and F1-3 and/or G and G1-3.

FOURTH AND FIFTH SPECIFICATIONS

PRACTICING WITH GROSS NEGLIGENCE

Respondent is charged with practicing with gross negligence on a particular occasion within the meaning of N.Y. Educ. Law Section 6530(4)(McKinney Supp. 1994). Specifically, Petitioner charges:

4. The facts in Paragraph C and C1-3.

5. The facts in paragraph E and E1-3.

SIXTH THROUGH ELEVENTH SPECIFICATIONS

FAILURE TO MAINTAIN RECORDS

Respondent is charged with failure to maintain a record for each patient which accurately reflects the evaluation and treatment of the patient within the meaning of N.Y. Educ. Law Section 6530(32)(McKinney Supp. 1994). Specifically, Petitioner charges:

6. The facts in Paragraph B.

7. The facts in Paragraph C and C1-3.

8. The facts in Parqgraph D and D1, 2 and 4.

9. The facts in Paragraph E and E1-2.

10. The facts in Paragraph F and F1-2.

11. The facts in Paragraph G and G1-2.

DATED: New York, New York
June 14, 1994

CHRIS STERN HYMAN
Counsel
Bureau of Professional
Medical Conduct